

Outpatient treatment of syphilis with penicillins

We would like to draw the attention of colleagues to a proposed change in the recommended dosage for bemethamine penicillin (Triptopen) when used in late syphilis. Following discussions with one of us (PCG) the manufacturers (Glaxo Laboratories) are seeking approval from the Department of Health that the current approved dosage of two vials weekly¹ be replaced with a recommended dosage of one vial administered twice weekly for three weeks. This is because blood levels produced by the latter regime can be shown to be above 0.03 u/ml immediately prior to the next dose² whilst no such confirmation is available for the existing recommendations.

Triptopen is currently the only licensed penicillin product suitable for routine outpatient treatment of syphilis. This follows the commercial demise of alternative long acting penicillin preparations. It is true that these or similar products remain available under Section 13¹ of the Medicines Act 1968 on a "named patient" basis. However, the use of non-licensed products is fraught with difficulty, as treatment is usually required to commence immediately on diagnosis, so the delay which may occur in obtaining "named patient" supplies would be unacceptable (unless manufacturers bend the rules and accept retrospective names) and, in addition, the release of patient names in these circumstances may be in breach of the anonymity demanded by the National Health Service (Venereal Diseases) Regulation 1974.

The use of a non-licensed product in favour of an effective licensed product may produce medicolegal problems for the prescriber in the event of an adverse event occurring (Medical Protection Society, personal communication).

The new dosage recommendations for Triptopen should remove the previous uncertainty concerning the maintenance of adequate blood levels during the treatment of late syphilis and will present prescribers with a licensed source of penicillin suitable for the outpatient treatment of late syphilis.

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- 1 Triptopen Data Sheet. ABPI Data Sheet Compendium 1989-90.
- 2 Data on File. Glaxo Laboratories.

MATTERS ARISING

Gastrointestinal obstruction associated with Chlamydia trachomatis

The paper by Pegg and Owen¹ describing a case of gastrointestinal obstruction associated with *Chlamydia trachomatis* in an 18 year old female brought a similar case to our minds.

An 18 year old schoolgirl presented with an acute intestinal obstruction. Operation revealed a peritonitis with adhesive bands running from the omentum to the Fallopian tubes with bilateral salpingitis and tubo-ovarian abscesses. Her post-operative history was rather stormy and 4 years later she is still troubled by low abdominal pain and menorrhagia.

Because of the operative findings the patient was referred to the Special Treatment Clinic and aspects of her history not revealed before were voiced. She had had only one boy friend with whom she had her first and only sexual contact several weeks before the onset of her symptoms. No protection had been used. The boy friend, an older student resident in the United Kingdom, had a history of recent chlamydial urethritis.

Initial post-operative vaginal specimens were negative but later testing produced a positive reaction for *Chlamydia trachomatis*. The patient also developed a vaginitis with plaques which yielded *Candida albicans*. Both conditions responded to specific treatment.

This young lady missed a crucial years schooling and has suffered symptoms on and off for 4 years following the single unprotected contact with a thoughtless young man.

The consequences of infection with chlamydia in females can be devastating, and as Pegg and Owen warn the possibility of such a cause for adhesive small bowel obstruction or unexplained peritonitis should be considered.

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- 1 Pegg DJ, Owen AWM. Gastrointestinal obstruction associated with *Chlamydia trachomatis*. *Genitourin Med* 1990;66:26-7

Post-gonococcal urethritis: a double blind study of doxycycline

I read with interest, the recent article by McLean *et al*¹ entitled "Post-gonococcal urethritis: a double-blind study of doxycycline vs placebo", describing the significant reduction of postgonococcal urethritis (PGU) by the addition of a course of tetracycline to standard single dose treatment for urethral gonorrhoea in heterosexual men.

I would be interested to know, however, the number of patients with PGU who returned for a second follow-up at 28 days and in spite of receiving doxycycline, continued to show evidence of PGU; and the management offered to those 30 patients who at the 1st follow-up, were still found to have PGU in the doxycycline group. It would be useful to know the number of men in whom *C trachomatis* was not isolated in the PGU and non-PGU group, who were consorts of women with chlamydial infection. Also, it is not mentioned in the article whether the study population has been advised to abstain from sexual intercourse during the follow-up period and the number of men in the PGU and non-PGU group who followed this advice.

Moreover, doxycycline was ineffective in 30 (26.8%) men in the treatment group (N = 112), and 50 (48%) men in the placebo group would have had unnecessary medication had they been given routine tetracycline in conjunction with single dose therapy for genital gonococcal infection. In other words, 37% (80/216) men in this study would have received a potentially hazardous medication without any benefit. This should concern us all, more so in the light of emerging plasmid and chromosomal mediated resistant strains of *N gonorrhoeae*, which may have serious implications in the future. This concern has been shared in the recent editorial of this journal² in which it has been suggested that widespread use of tetracyclines may be contributing to this problem. *C tra-*